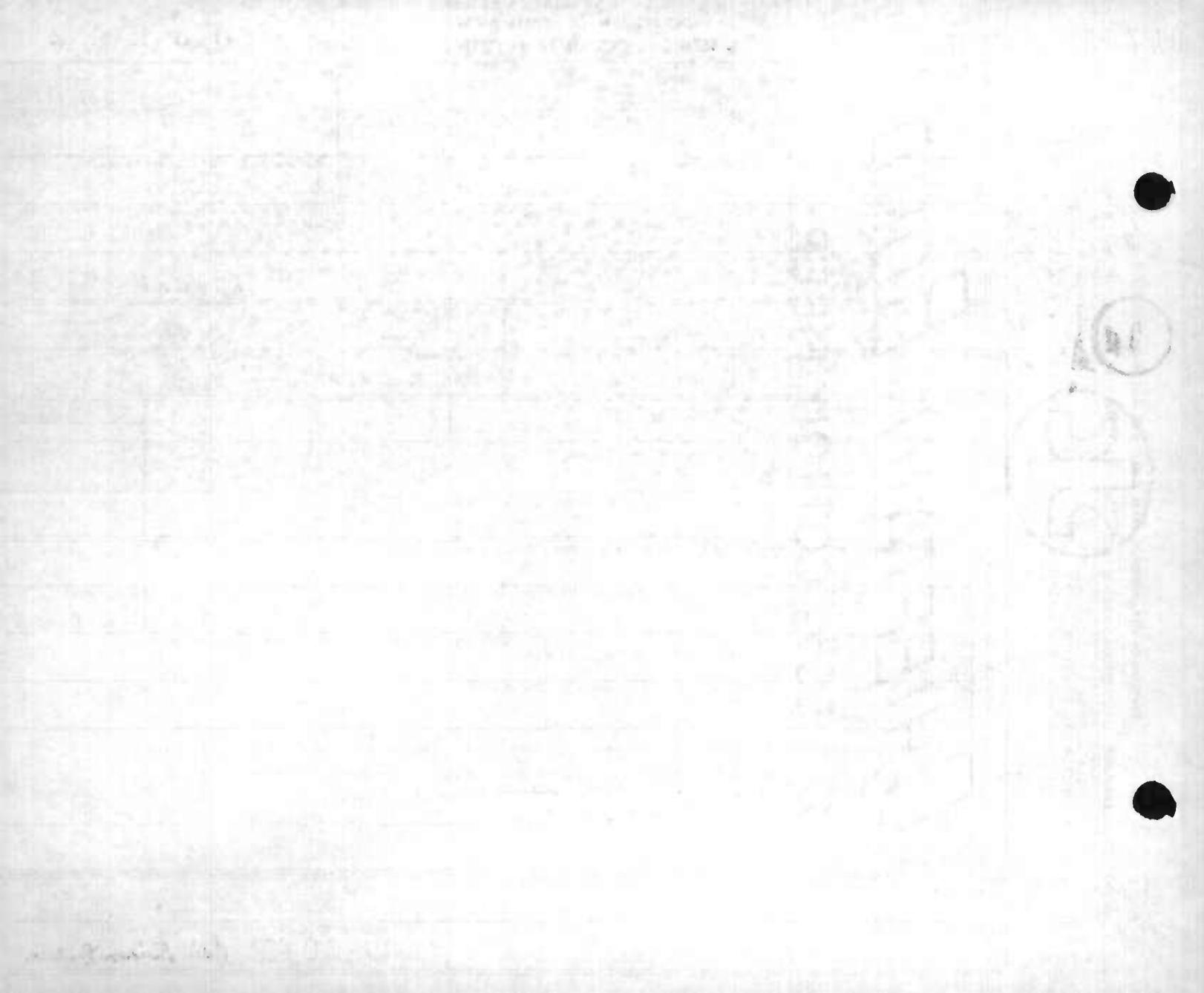


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 AND 5 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 8 2 4 2						
1. DECEASED NAME (TYPE OR PRINT)			FIRST DENNIS	MIDDLE COULBOURNE	LAST BAKER	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH MAR 12	DAY 1987	YEAR 1700Q	7b. HOUR 2d HOUR				
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH JUNE DAY 17 YEAR 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY				
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARM MANAGER						12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
13a. STATE DELAWARE		13b. COUNTY KENT		13c. CITY OR TOWN CLAYTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS DELAWARE STATE RT. 6/19938			99999				
14. FATHER'S NAME FIRST CHARLES			MIDDLE	LAST BAKER	15. MOTHER'S MAIDEN NAME FIRST GRACE			MIDDLE	LAST COULBOURNE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT WANDA B. CREIGHTON			ADDRESS RT. 4, BOX 215 CAMBRIDGE, MD 21613							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF				
(b)												DUE TO, OR AS A CONSEQUENCE OF				
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE		TITLE (SPECIFY) Peter W. Rieckert, M.D. Dep. MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M.D. ADDRESS East New Market, Md. 21631																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-15-87			23c. NAME OF CEMETERY OR CREMATORIUM UNITY WASHINGTON CEM			23d. LOCATION CITY OR TOWN HURLOCK			COUNTY DORCHESTER	STATE MD			
24. FUNERAL DIRECTOR NAME ZELLER			ADDRESS ZELLER FUNERALHOME, EAST NEW MARKET, MD			25a. DATE REC'D. BY REGISTRAR MAR 20 1987			25b. REGISTRAR'S SIGNATURE Julia S. Rieckert-Randall							
DHMH - 17 (VR A15 ME (5))																



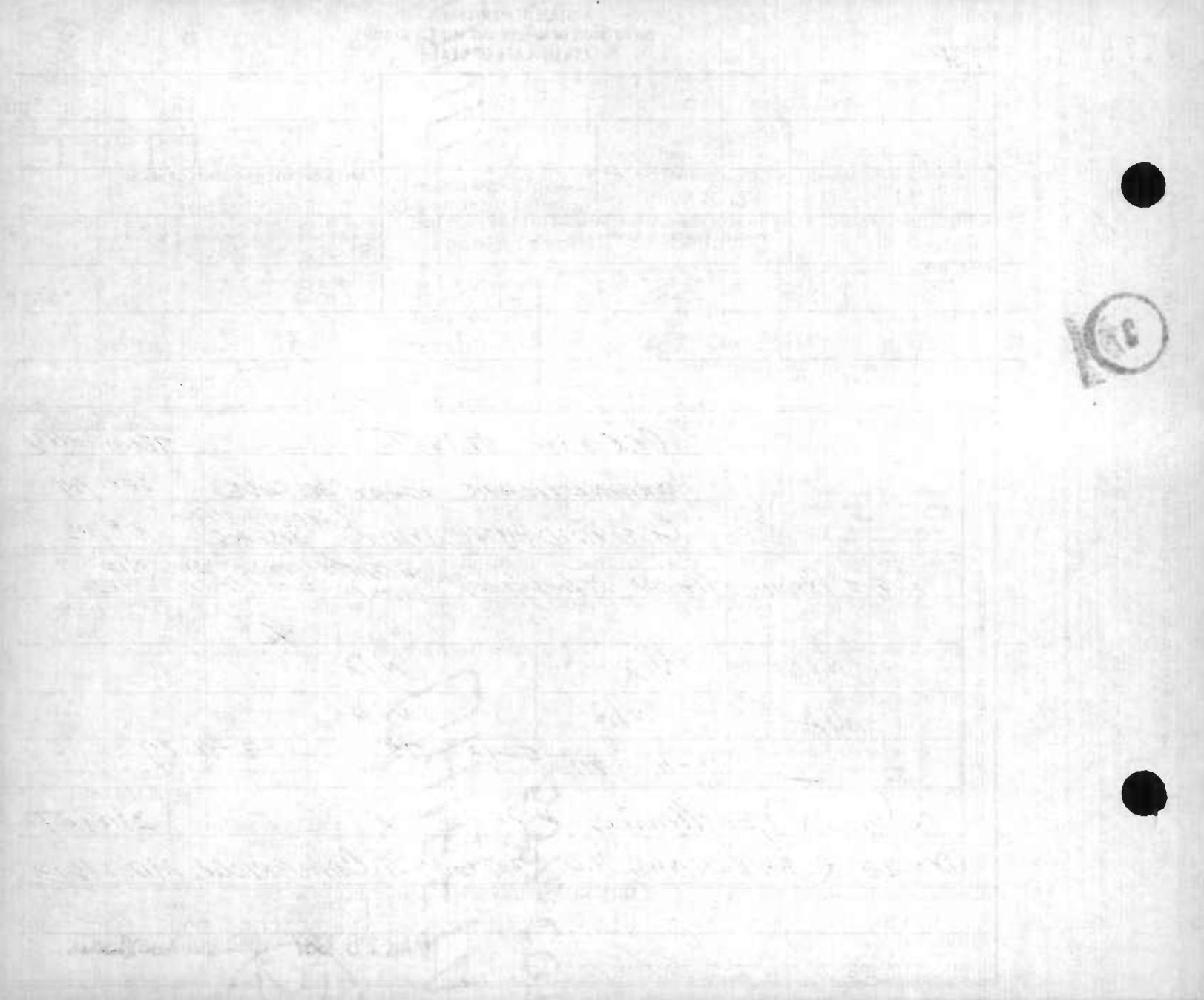
047373 MAR 17 1987  
hours after death. Page 4 may be

RE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be retained or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108243	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
Novella Mae Baldwin						March 11 1987						11:55pm	
3. SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5/24/1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.							
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) State of Md.			12b. KIND OF BUSINESS OR INDUSTRY ret.						
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2 Oak St.		21613			
14. FATHER'S NAME FIRST John MIDDLE Mace LAST Tolley				15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE R. LAST Lewis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-07-7788		17. INFORMANT Doug T. McConnell		ADDRESS Rt 2 Box 69 AA5 Cambridge Md.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> 80-499 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TEN MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u> <u>Cardiovascular Disease</u> 10+ yrs													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVING RISE TO DEATH <u>Recent Pneumonia (boggy - rt. lower lobe) with emphysema and hypoxia - compensated</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <u>11</u> MONTH <u>5</u> DAY <u>13</u> YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 <u>N/A</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) <u>N/A</u>		21f. LOCATION STREET <u>N/A</u> CITY OR TOWN COUNTY <u>CITY OF BALTIMORE</u> STATE <u>MD</u>									
22a. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> 19 <u>77</u> to <u>3-11</u> 19 <u>75</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Donald R. Williams, M.D.</u>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/12/87							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DONALD R. WILLIAMS, M.D.</u>		22f. ADDRESS <u>308 Gray St. Cambridge, MD. 21613</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/14/87		23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK		23d. LOCATION CITY OR TOWN <u>CAMBRIDGE</u> COUNTY <u>DOR.</u> STATE <u>MD.</u>							
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.		ADDRESS MAR 16 1987		REGISTRATION NUMBER Signature									
DHMH-16 50M 7/77 (VR A 15 (4))													



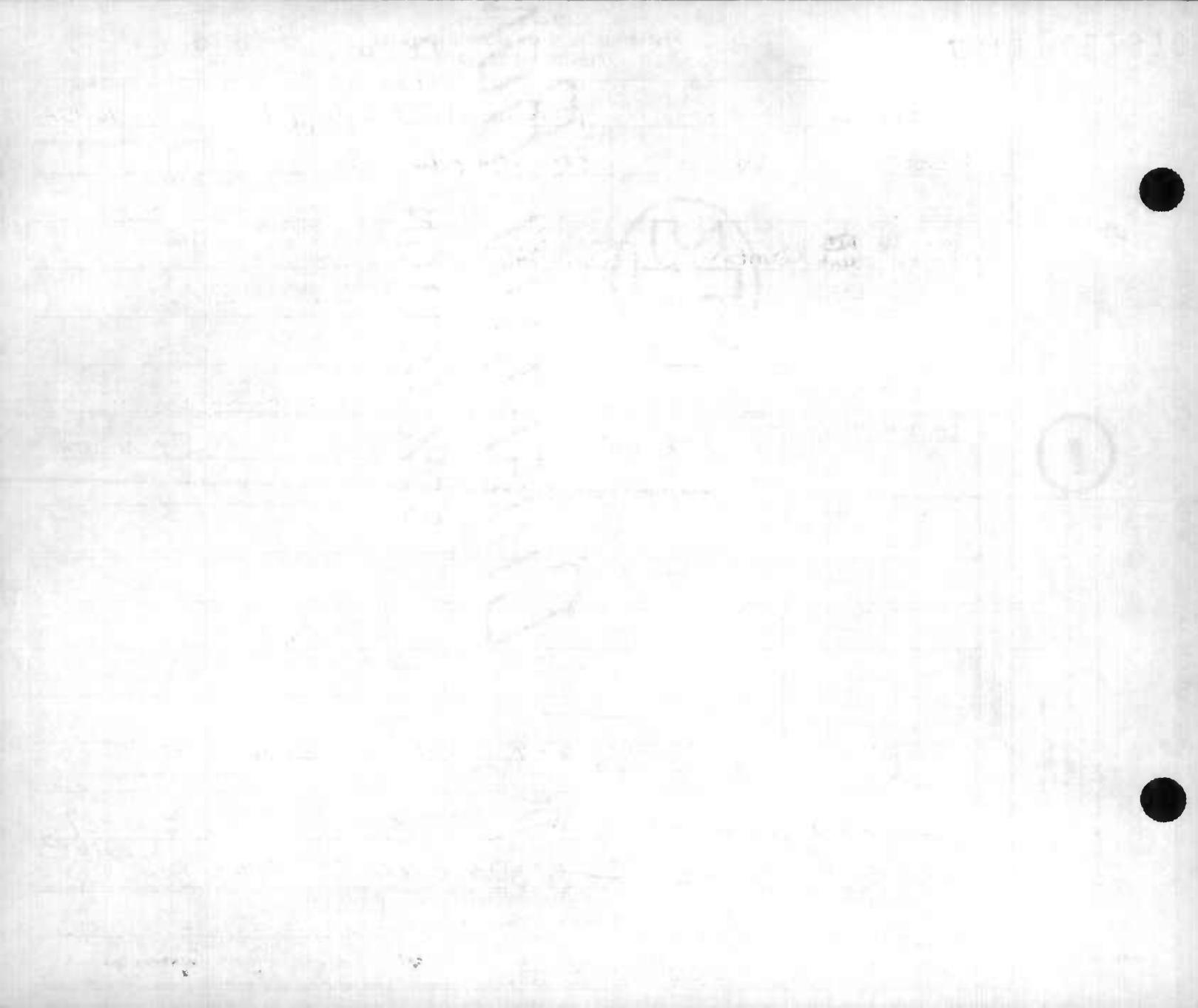
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove from page 3 and attach to the burial/transit permit. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 is checked, injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8708244			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Grace Thomas					BOCA Raton	3/6/87				10:55 AM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH 09	DAY 09	YEAR 01	85	YRS	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		US		NSR HOME		Dorchester Co.							
10 CITY OR TOWN OF DEATH Cambridge MD Dorchester County													
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House													
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Crapo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		13e. STREET ADDRESS / ZIP CODE N/A 21626		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME FIRST William		MIDDLE Thomas		LAST Wingate		15. MOTHER'S MAIDEN NAME FIRST Abijah		MIDDLE		LAST Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		Rt 2 Box 69 AA1 Brady H. Bradford Cambridge, Md. 21613					
No		214-10-0899											
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) STROKE													
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) this hospital attended the deceased from 3-7 1987 to 3-6 1987, that (I) we last saw the deceased alive on 3-6 1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (I) did (did not) view the body after death.													
22b. SIGNATURE Michael A. Moskewicz		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ		22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 3/10/87		23c. NAME OF CEMETERY OR CREMATORIAL Wingate		23d. LOCATION CITY OR TOWN Wingate		23e. COUNTY Dor. Md.		23f. STATE			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 09 1987		25b. REGISTRAR'S SIGNATURE James Anderson, Esquire							



046693 MAR 11-87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

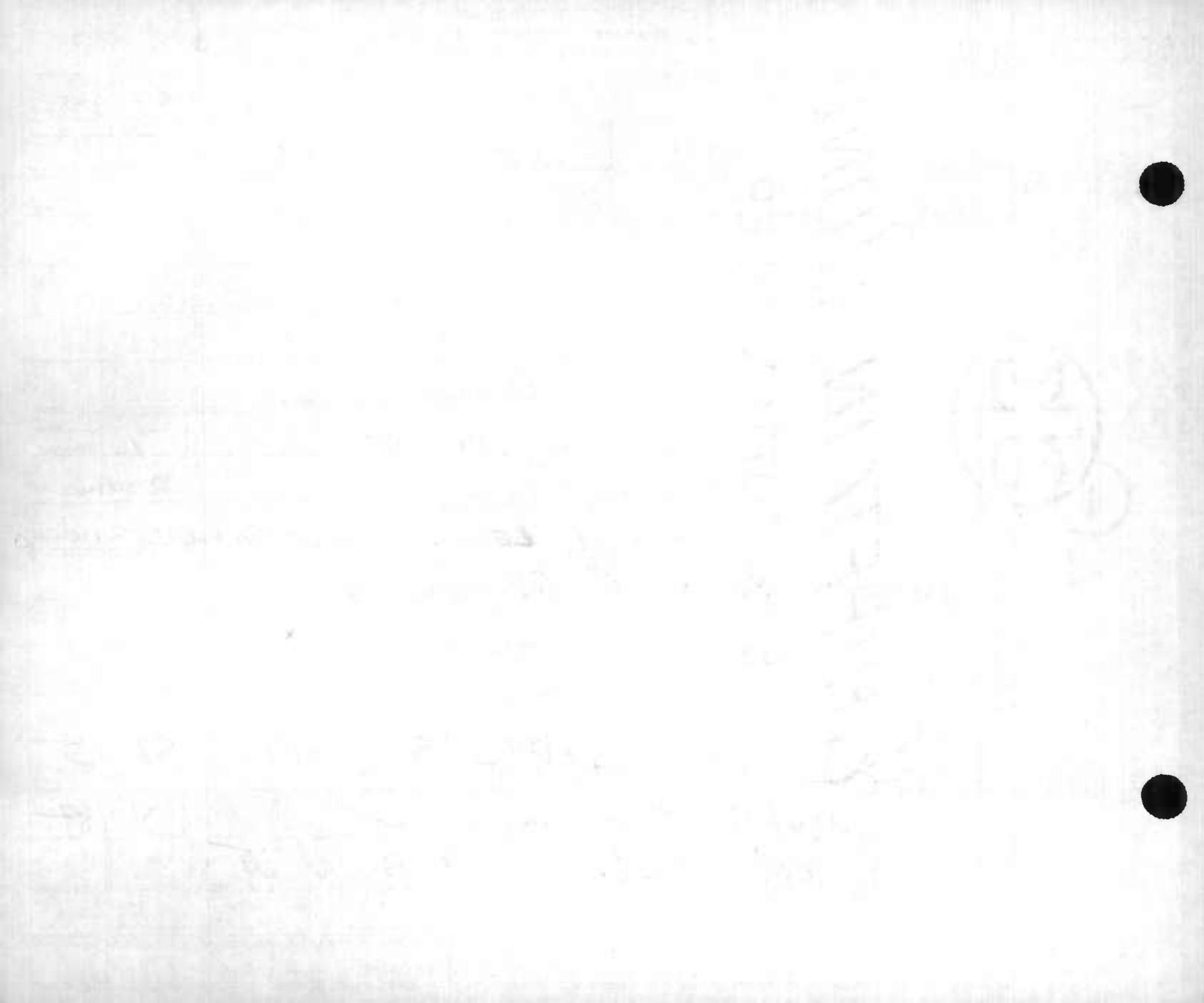
8108245

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN ELIZABETH BRAMBLE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3 7 87</b>	2b. HOUR <b>9:58 AM</b>
3. SEX <b>F</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 13 03</b>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>83 yrs</b>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b>	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>DORCHESTER GENERAL HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>DORCHESTER</b>	13c. CITY OR TOWN <b>CAMBRIDGE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>21613 702 Peachblossom Ave.</b>	
14. FATHER'S NAME FIRST <b>JOHN</b>	MIDDLE <b>G.</b>	LAST <b>BENNETT</b>	15. MOTHER'S MAIDEN NAME FIRST <b>LEILA</b>	MIDDLE	LAST <b>LOWE</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-10-6396</b>	17. INFORMANT <b>daughter</b>	ADDRESS <b>ELIZABETH COX same as 13e</b>		
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a), (b) AND (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Acidosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>MASSIVE GI BLEEDING FROM GASTROESOPHAGEAL VARICES</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min 24 hrs</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>PULMONARY EDEMA, CHT. &amp; Pneumothorax</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on <b>3/7/87</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7/87</b> to <b>3/7/87</b> , that (I) (we) lost saw the deceased alive on <b>3/7/87</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)					
22b. SIGNATURE <b>HUBERT L. FERRY</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>3/7/87</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT L. FERRY</b>	22e. ADDRESS <b>503 BYRD ST.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>Mar. 10, '87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Dorchester Mem. Pk.</b>	23d. LOCATION CITY OR TOWN <b>Airey, Dorchester, Md.</b>	23e. COUNTY <b>MD</b>	23f. STATE <b>MD</b>
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Jeanne F. Johnson</b>			
ADDRESS <b>308 High St., Cambridge, Md. 21613</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death, reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, removal, or cremation.

IMPORTANT: If Item 21 is marked or checked, notify medical examiner.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper from the back of this page and attach it to the burial-transit permit. This form must be mailed or faxed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event in the life of the deceased, the physician must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0708246	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
William Elmer Brittingham					March 26, 1987					4:00A M	
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Male		White		Feb 24, 1909					IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS HOURS MIN		
Maryland		US				Dorchester Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Golden Hill		Smithville Road								Carpenter	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland		Dorchester		Golden Hill					Smithville Road		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		FIRST MIDDLE LAST					
		Charles C. Brittingham		Edith		Todd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Star Rt Box 638			
No		214-12-5573		Bertha Brittingham Church Creek, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Atherosclerosis											yes
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension, COPD, Peripheral Vascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/16/87 to 3/26/87, and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		3/26/87			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		503 BYRN ST							
Hubert L. Feeny											
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		3/28/87		Oak Grove Cemetery		Golden Hill Dor. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME CAMBRIDGE, MD.				APR - 6 1987		Julia Scoville Landales					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or transportation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be filled in.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8108241					
1 - STATE REGISTRAR [TYPE OR PRINT]			1. DECEASED NAME <b>MAGDALENE E. CHRISTOPHER</b>			2d. DATE OF DEATH <b>3/20/87</b>			2d. HOUR <b>3:35 PM</b>						
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH <b>12</b> DAY <b>5</b> YEAR <b>10</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>			7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
9. BIRTHPLACE COUNTRY <b>Md.</b>			10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			13b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>			
13. STATE <b>Md</b>			13a. COUNTY <b>Dorchester</b>			13c. CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Crusader Arms Apt. 504 21613</b>			
14. FATHER'S NAME FIRST <b>WILLIAM</b>			MIDDLE <b>HENRY</b>			LAST <b>TRAVERS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b>			MIDDLE <b>VIRGINIA</b>		LAST <b>LEWIS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-24-0420</b>			17. INFORMANT <b>Audrey Furbush</b>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b>															
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHF</b>															
DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION <b>/</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>/</b>						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. <b>—</b> MONTH <b>—</b> DAY <b>—</b> YEAR P.M. <b>—</b> 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>			21f. LOCATION STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>									
22a. I certify that (I) (this hospital) attended the deceased from now the deceased alive on <b>3/19/87</b> , to <b>3/20/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>3/20/87</b>					
22b. SIGNATURE <b>Christopher</b>										22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VINODRAJ MEHTA</b>			22f. ADDRESS <b>400 Aurora St Cambridge Md 21613</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>3/21/87</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Dor. Memorial Pk.</b>			23d. LOCATION CITY OR TOWN <b>Cambridge</b> COUNTY <b>Dor.</b> STATE <b>Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1987</b>			
24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home Cambridge Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Sanderson-Lindale</b>												
DHMH - 16 60M 7/84 (VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please sign and mail it with the State Dept. of Health and Mental Hygiene prior to burial. In case of an emergency, attach a separate sheet of paper and mail it at once.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, air or gaseous material must be noted at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08248	
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Eugene S. Cooke</i>						<i>March 18, 1987</i>				<i>3:55 AM</i>	
3 SEX		4 RACE		5. DATE OF BIRTH		31					
<i>Male</i>		<i>White</i>		MONTH	<i>7</i>	DAY	<i>30</i>	YEAR	<i>15</i>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
<i>Cambridge, Md.</i>		<i>USA</i>						<i>Baltimore Co. Cambridge</i>		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS			
<i>Cambridge</i>		<i>Eastern Shore Hospital Center</i>		<i>Bus Driver</i>		<i>PUBLIC TRANSPORTATION</i>		<i>10 Hopewell Trailer Park</i>			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
<i>Md.</i>		<i>Som.</i>		<i>Crisfield</i>		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	<i>10 Hopewell Trailer Park</i>			
14 FATHER'S NAME FIRST		MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	16 ADDRESS			
<i>James</i>		<i>E.</i>	<i>Cooke</i>	<i>Laura</i>		<i>J.</i>	<i>EVANS</i>	<i>11 Pear St.</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES		16b SOCIAL SECURITY NO		17 INFORMANT		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>NO</i>		<i>218-03-4052</i>		<i>SALLY E. COOKE - CRISFIELD, MD 21817</i>		<i>Immediate</i>					
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18b DUE TO, OR AS A CONSEQUENCE OF (b)		18c DUE TO, OR AS A CONSEQUENCE OF (c)		18d					
<i>Cardiac arrest</i>		<i>General debility, dementia</i>				<i>12 years</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a											
<i>None</i>											
19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IN EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a I certify that (this hospital) attended the deceased from <i>Oct 16, 1975</i> to <i>Mar 18, 1987</i> , that (we) lost saw the deceased alive on <i>Mar 18, 1987</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input checked="" type="checkbox"/> did not view the body after death.											
22b SIGNATURE <i>Paul A. Stagg MD</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <i>Mar. 18, 1987</i>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul A. Stagg</i>		22e ADDRESS <i>Box 800 Cambridge, Md 21613</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3/21/87</i>		23c NAME OF CEMETERY OR CREMATORIUM <i>SUNNYRIDGE Cemetery</i>		23d LOCATION CITY OR TOWN <i>CRISFIELD Somerset</i>		STATE <i>MD</i>			
24 FUNERAL DIRECTOR NAME <i>Braddock &amp; Sons</i>		ADDRESS <i>21817 CRISFIELD, MD.</i>		25a DATE REC'D. BY REGISTRAR <i>Mar 23, 1987</i>		25b REGISTRAR'S SIGNATURE <i>John H. Johnson</i>					
BP _____											
DHMH-16 25M (VRA 15, 4) 1/79											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8708249

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Part 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial permit or carbon copies. Pages 1 and 2 should be retained by the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner has noted on

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST Anna MIDDLE Laura LAST Duvall			2d DATE OF DEATH MONTH DAY YEAR 3-12-87	MONTH YEAR 11 15 11 27 M	2b HOUR 11 27 M			
3. SEX Female		4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 28 98		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S. U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worchester Co MD.			
10. CITY OR TOWN OF DEATH Car朋ge and		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hosp Center		12a. USUAL OCCUPATION Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13. USUAL RESIDENCE / HOME OR OTHER INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Howard		13c. CITY OR TOWNSHIP Ellicott City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5038 Ducham Road W. 21043		
14. FATHER'S NAME First Robert M. Athur		15. MOTHER'S MAIDEN NAME Sarah F. Helen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 213-56-7140		17. INFORMANT Mrs. Hiltrude D. Caine (Daughter) ADDRESS 227 Canal Park Drive, Apt. 105, Salisbury, Md. 21801		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart failure, intestinal diarrhea</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized Arteriosclerosis, per. abd. Abscess.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-10-79 to 19 to 1987, that (I) (we) last saw the deceased alive on 3-12-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>M. Razavi M.D.</u>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED 3-12-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Razavi M.D.</u>		22e. ADDRESS Eastern Shore Hospital Center						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/16/1987		23c. NAME OF CEMETERY OR CREMATORIAL Linden-Linthicum Chapel Cemetery		23d. LOCATION Clarksburg, Howard, Maryland		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME		ADDRESS Snow Hill Rd Sat.		25a. DATE REC'D. BY REGISTRAR MAR 17 1987		25b. REGISTRAR'S SIGNATURE Julia Debra L. Parker		

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1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, return it to me, funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 21B, show injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 048263 MAR 27 1987 08250	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
NICIE			O		EDMONDS		3/17/87				8:25PM
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
F			NEBRO	MONTH	DAY	YEAR	MONTHS	YEARS	HOURS	MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.			U.S.				Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			Dorchester Gen Hospital								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
			Md.		Dorchester		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		834 Park Lane 21613		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Thomas				Spicer	Essie		P.	Stanley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
(YES, NO OR UNKNOWN)			220-28-4270		Tamaqua Payne						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of lung											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo
DOUE TO, OR AS A CONSEQUENCE OF (b) { DOUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Severe Anemia, Smoking											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 21)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from 3/17/87 to 3/17/87, that (I/we) last saw the deceased alive on 3/17/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22b. SIGNATURE Hubert L. Flory			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Flory			22e. ADDRESS 503 BYRN ST								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/21/87		23c. NAME OF CEMETERY OR CREMATORIAL MEETKINS NECK CEM. CHURCH CREEK, DARE, MD.		23d. LOCATION CITY OR TOWN			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Stewart Funeral Home			ADDRESS Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR MAR 26 1987			25b. REGISTRAR'S SIGNATURE			



047366 MAR 17 STATE 4-287 AL  
FOR REGISTRAR per phone.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 should be detached for use as the burial permit. Then please stamp carbon copy to Burial Director or Medical Examiner.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please stamp carbon copy to Burial Director or Medical Examiner.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury or other traumatic cause of death, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08251	
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			20. DATE OF DEATH			26. HOUR	
LEVIN. J						FISHER.			3 1 87			4 23 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
M.		BLACK		MONTH	4	DAY	20	YEAR	75	YEARS	+	HOURS	MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Md.		U.S.						DORCHESTER					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE		DORCHESTER GENERAL H.			RET								
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD		Dor		CAMBRIDGE		Route 1 Box 40 21869							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John		Carrie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
		214-16-4524			Delphine Gaires								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
RESPIRATORY INSUFFICIENCY													
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIOGENIC CARCINOMA													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a HYPERCALCERmia.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
—		—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SPECIFY IN MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FIELD, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (we) attended the deceased from now the deceased died on 3.3.1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
H. K. WILKE								3.4.87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE			
Burial		Mar. 7, 1987		John Wesley Cem. Vierra Dorchester Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Stewart Funeral Home		Cambridge, Md.			MAR 16 1987			K. McDonald-Pandale					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-tranit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108252									
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
			CELIA D. JAMES						3-20-87												
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR											
FEMALE		CAU.		SEPT. 23, 1902			84 YRS.			MONTHS DAYS HOURS MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			10. CITY OR TOWN OF DEATH DAILSVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME "JAMESWAY FARMS"			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN DAILSVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RURAL			14. FATHER'S NAME THOMAS			15. MOTHER'S MAIDEN NAME LAWSON SOPHIA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-74-8146		17. INFORMANT DAUGHTER MRS. JANICE EDMONDSON			18. ADDRESS RIVERSIDE DR. PO BOX 724, CAMBRIDGE			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years											
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sporotrichosis cellulitis pneumonia b. lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 17 1987</i> , to <i>Mar 19 1987</i> , that (I) (we) last saw the deceased alive on <i>Mar 17 1987</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																					
22b. SIGNATURE <i>Lewis M. Burdette MD</i>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>Mar 21 1987</i>													
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lewis M. Burdette</i>		22g. ADDRESS 4 Aurora St Cambridge Md 21613			22h. ADDRESS East New Market Cem. East New Market, Dor., Md.			22i. COUNTY STATE													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/22/87			23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cem.			23d. LOCATION CITY OR TOWN													
24. FUNERAL DIRECTOR NAME Curran Funeral Home Cambridge, Md. 21613		25a. DATE REC'D. BY REGISTRAR MAR 24 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Burdette</i>			25c. STATE Md.													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than "No" to show any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8708253			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Jennie L. Lord</i>					<i>Lord</i>	MARCH	6	1987		7:45 P.M.			
3. SEX	4 RACE				5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
<i>F</i>	WHITE				SEPTEMBER	5	1893		IF UNDER 1 YEAR MONTHS DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY					
MARYLAND		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE		DORCHESTER GENERAL			HOMEMAKER			MD.					
13a. STATE MD										13b. COUNTY DORCHESTER	13c. CITY OR TOWN SECRETARY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE ACADEMY STREET/21664
14. FATHER'S NAME FIRST WILLIAM										15. MOTHER'S MAIDEN NAME FIRST EMMA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. - - - - -	17. INFORMANT P. O. BOX 324 DONALD V. LORD, SECRETARY, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Uremia. Anemia</i>													
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 6 1987</i> , to <i>Mar 6 1987</i> , that (I) (we) last saw the deceased alive on <i>Mar 6 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Lewis M Burdette MD</i>										DEGREE	22c. DATE SIGNED <i>3/6/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lewis M Burdette</i>		22e. ADDRESS <i>4 Aurora St Cambridge MD 21613</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-9-87			23c. NAME OF CEMETERY OR CREMATORIUM EAST NEW MARKET CEM.			23d. LOCATION CITY OR TOWN EAST NEW MARKET, DORCHESTER, MD					
24. FUNERAL DIRECTOR NAME <i>ZELLER FUNERAL HOME, EAST NEW MARKET, MD</i>										25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1987</i>			
										25b. REGISTRAR'S SIGNATURE <i>Lewis M Burdette</i>			

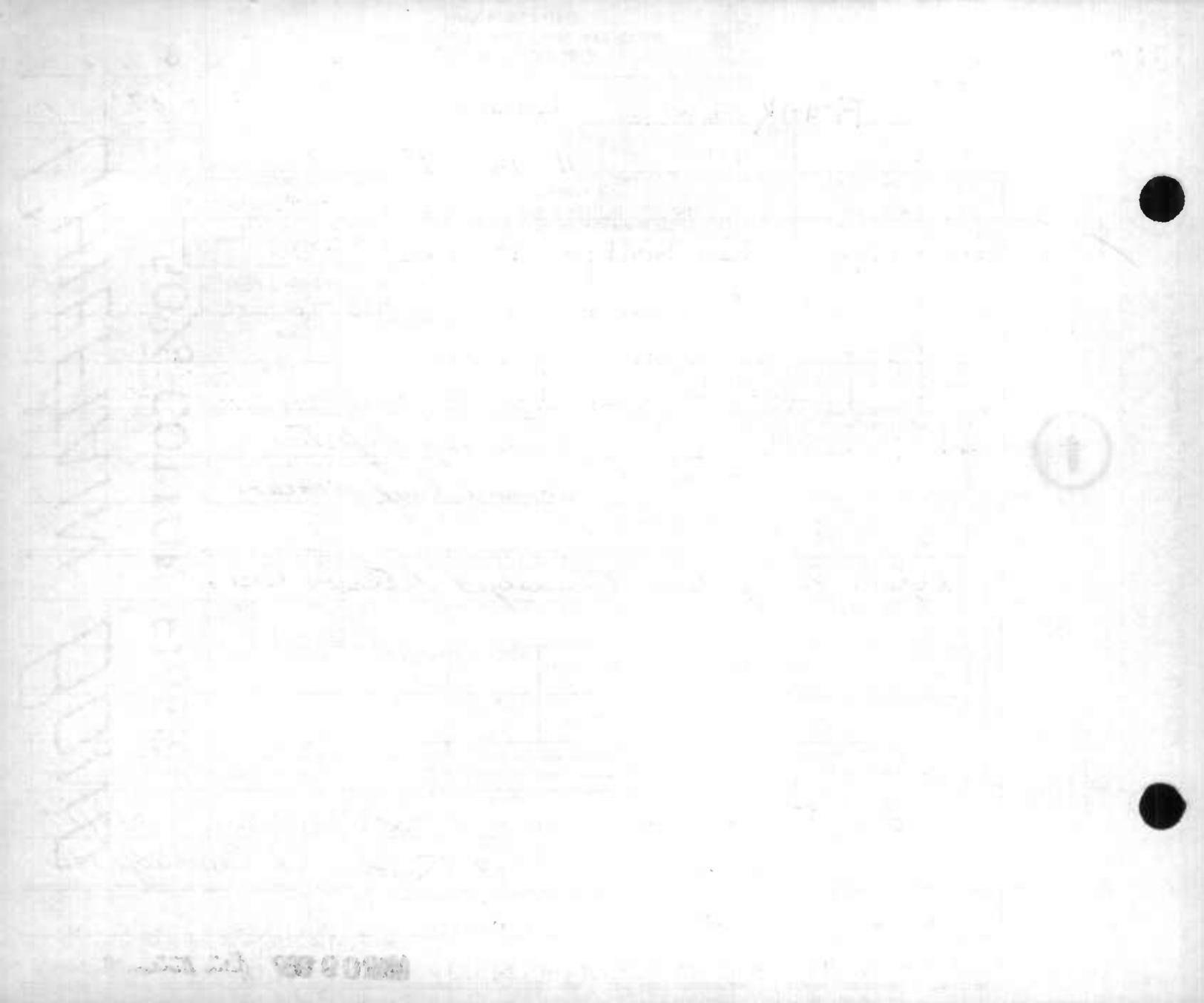
2009-01-01 00:00:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it must be filed in the funeral director's office. Then please remove the tape. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on Item 8, show entry injury, or other traumatic cause of death, attach a medical report.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 046793 08254		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Frank Watkins			Lucas			3 9 87			8:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		11 12 98			88			YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
New Jersey		U.S.					Dorchester Co.			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cambridge		Cambridge House		Retired										
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland		Dorchester		Cambridge			520 Glenburn Ave 21613							
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			ADDRESS							
William		Lucas		Lillian			Cambridge, Md.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			LAST							
Yes		WW I 222-09-3703		Beverly Abbot			Watkins							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary infection</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic lung disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia: <i>Organic B syndrom, Generalized Arteriosclerosis</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 31/4/87		
22b. SIGNATURE <i>E. Tannan</i>		22d. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 17 Franklin St. Cambridge, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/87		23c. NAME OF CEMETERY OR CREMATORIAL Md. Vets Cemetery			23d. LOCATION CITY OR TOWN Hurlock			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD 21613		ADDRESS THOMAS FUNERAL HOME CAMBRIDGE, MD 21613			25a. DATE REC'D. BY REGISTRAR MRO 9 1987			25b. REGISTRAR'S SIGNATURE Julie Johnson-Lindner						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remit \$1.00 to the State Dept. of Health and Mental Hygiene prior to burial, otherwise, a removal fee will be charged.

IMPORTANT: If item 21 is marked or shows any injury, or other disease, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 08255											
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT) <b>Frederick W. FRED Warrington Lucas</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>3 11 87</b>				2b. HOUR <b>3:55A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 19 03</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b>			
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DGH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dor Co. Treasurer Retired</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>711 Maryland Ave 21613</b>			
14. FATHER'S NAME FIRST <b>William</b>		MIDDLE <b></b>		LAST <b>Lucas</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b>		MIDDLE <b></b>		LAST <b>Watkins</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>No 185-07-7563</b>		17. INFORMANT <b>Lola C. Lucas Item # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Ca, Squamous cell</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>											
DUE TO, OR AS A CONSEQUENCE OF { (b) } DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Dehydration, Sepsis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) saw the deceased alive on <b>3/10 1987</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/8 1987</b> to <b>3/11 1987</b> , that (I/we) last saw the deceased alive on <b>3/10 1987</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
22b. SIGNATURE <b>Hubert L. Fiery MD</b>		22c. DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>3/11/87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT L. FIERY MD</b>		22e. ADDRESS <b>503 BYRN ST</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/13/87</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Dor Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Cambridge Dor</b>		CITY OR TOWN <b>Dor</b>		STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME CAMBRIDGE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1987</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>					
DHMH - 16 60M 7/B4 (VRA 15, 4)											

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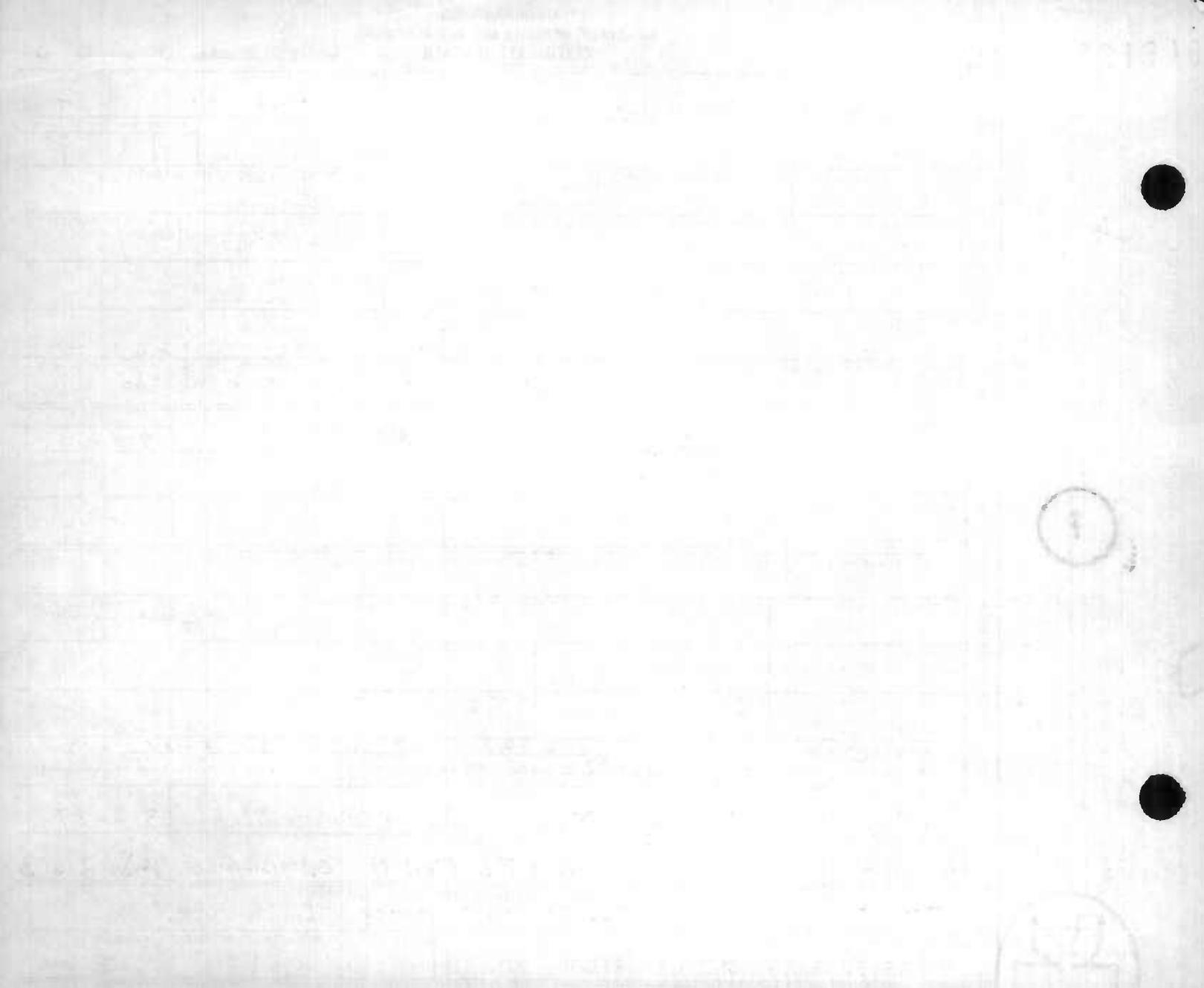
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial permit. Then please return carbon paper pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 0 8 2 5 6											REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Emma L. Louise McCulley						3-2-87						3 A M		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White		Month Day Year Feb 12, 1897			90 YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
Alabama			US					Dorchester Co.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cambridge			Dorchester General Hospital									Homemaker		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Dorchester		Vienna						Race Street			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Conrad			Billie			Mary			Etta			Daugherty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS			2169		
No			219-34-3907			Jerry McCulley			Cambridge, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CEREBRAL HEMORRHAGE									9 days.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2-22 1987, to 3-2 1987, that (I) (we) last saw the deceased alive on 3-1 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.												22c. DATE SIGNED 3-2-87		
22b. SIGNATURE Michael A. Moskewicz MD			DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/4/87			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery			23d. LOCATION CITY OR TOWN Vienna COUNTY Dor. STATE Md.			22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD. 21613		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR MAR 04 1987									25b. REGISTRAR'S SIGNATURE John R. Landau		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use on the burial-tranport permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8708257
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>WALTER</i>	MIDDLE <i>JAMES</i>	LAST <i>McGrath Josiah</i>	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
				<i>3/25/87</i>				<i>8:45 AM</i>				
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 14 HRS	2d. HOUR				
<i>M.</i>	<i>Negro</i>	MONTH <i>1-</i>	DAY <i>11-</i>	YEAR <i>1904</i>	<i>83</i>	MONTHS <i>0</i>	DAYS <i>0</i>	<i>8:45 AM</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Md.</i>	<i>USA</i>				<i>Dorchester</i>							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Cambridge</i>	<i>Dorchester General Hosp.</i>					<i>Laborer</i>			<i>Retired</i>			
13. STATE <i>Md.</i>	13b. COUNTY <i>Dor.</i>	13c. CITY OR TOWN <i>E.N.Mkt.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>RFD 1 P.O. # 8 21631</i>						
14. FATHER'S NAME FIRST <i>Josiah</i>	MIDDLE -	LAST <i>McGrath</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE <i>E. Pinder</i>	LAST <i>N.J.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)	17. INFORMANT <i>Leon McGrath 39</i>			ADDRESS <i>08046 BELMONT LA. WILLINGBOR</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>	<i>A20-26-2793</i>	(SON)										
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHF</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from now, the deceased alive on <i>3/24 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Mr. Mcgrath</i> DEGREE												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>400 AURORA ST.</i>				22e. ADDRESS <i>Commerce Ind 21613</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>Burial 3/28/87</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Zion U.M. Cem.</i>	23d. LOCATION CITY OR TOWN <i>E.N.Mkt.</i>	CITY OR TOWN		COUNTY		STATE				
24. FUNERAL DIRECTOR <i>L.H. Boardley Camb. Md. 21613</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 30 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson - Pendell</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or Item 18 shows any injury, or other trauma,

049115 MAR -208

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

0 8 2 5 8  
3 28 87 5 AM

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Elsie			A		McNamara	3	28	87	5 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female	white	10	23	01		85	YRS	MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Norchester	U.S.A.						Dorchester MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Cambridge	Cambridge House					writer				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY			
Ma	Nor.	Cambridge	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	520 Glenburn Ave. 21613		newspaper			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
Welsworth			mcnamara	Bessie meekins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO	212-16-1016	Gary V. McNamara		6 Sunset Lane Cambridge Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Atherosclerosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Organic B. syndrome, hypertension for years										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE	m.d.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN	COUNTY	STATE			
burial		3/30/87	CAMBRIDGE CEMETERY		CAMBRIDGE	DOR.	MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS	25a. DATE REC'D. BY REGISTRAR		25b. REGISTERED PERSON					
Thomas Funeral Home Camb. Md.		(C.P.N.)	APR - 1 1987		John Daniels, Esq.					

100-0-194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use on the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8708259	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
ELBA			May	MERRICK		Oct 23	1987	3	PM	6:30 PM			
3. SEX		4. RACE				5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
Female		White				Oct 22, 1899				87 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		US						Dorchester Co. MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Cambridge		Dorchester General Hospital						Homemaker					
13a STATE		13b COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Dorchester	Cambridge			X			520 Glenburn Ave 21613				
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
James		B.	Stephens	Rena				404 Talbot Ave					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT			Perry H. Messick Cambridge, Md 21613					
No		220-26-2968											
18 CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>udden.</u>	
(b) <u>Pneumia (Aspiration)</u>												<u>Days.</u>	
(c) <u>Gastroesophageal Reflux</u>												<u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1985</u> to <u>July 23, 1987</u> , that (I) (we) last saw the deceased alive on <u>3/23 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>H-E. Ayliffe</u>					DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/23/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H-E. Ayliffe</u>					22e. ADDRESS <u>408 BYRN ST. CAMBRIDGE MD.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Burial 3/26/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Dor Mem Park</u>			23d. LOCATION CITY OR TOWN <u>Cambridge Dor</u>		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <u>THOMAS FUNERAL HOME CAMBRIDGE, MD.</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 27 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Jin R.</u>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 8 2 6 0		
1. DECEASED NAME (TYPE OR PRINT)			FIRST EDWARD	MIDDLE MARTIN	LAST MULHERON	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 1	DAY 31	YEAR 1987	2b. HOUR 2:15PM		
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 12/11/1936		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 3 8 87 19		
7a. BIRTHPLACE HAWAII		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED XX NEVER MARRIED WIDOWED		8. DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER						
10. CITY OR TOWN OF DEATH WINGATE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION CRAZ POINT AREA			12a. USUAL OCCUPATION FOR MOST OR WORKING LIFE Data Prog'm Consul			12b. KIND OF BUSINESS OR INDUSTRY Investment					
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4504 WETHERILL RD. 20816			
14. FATHER'S NAME FIRST EDWARD			MIDDLE SANFORD			LAST MULHERON			15. MOTHER'S MAIDEN NAME FIRST MERCEDES			MIDDLE SULLIVAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES			16b. SOCIAL SECURITY NO. KOREA 1954-58			16c. ADDRESS 577-44-5139			17. INFORMANT wife E. M. Mrs. <del>X</del> Rieckert			ADDRESS Mulheron (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:  8309 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1-31 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) boat capsized								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Water			21f. LOCATION STREET Crab Point near Wingate, Md. CITY OR TOWN COUNTY 21675 STATE Dor.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter W. Rieckert, M.D. M.D. Dep. MEDICAL EXAMINER												DATE SIGNED 3-9-87		
EXAMINER'S NAME (TYPE OR PRINT)			EXAMINER'S ADDRESS Peter W. Rieckert, M.D. East New Market, Md. 21631											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 3-9-87			23c. NAME OF CEMETERY OR CREMATORIAL SECURITY PROCESS			23d. LOCATION CITY OR TOWN CATONSVILLE, BALTIMORE, MD.					
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME 308 High St., Cambridge, Md. 21613			25a. DATE REC'D. BY REGISTRAR MAR 09 1987			25b. REGISTRAR'S SIGNATURE Julia Dandrea								
15M 2/80														
DHMH-17 (VR A15 ME (5))														

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**TOP HOSPITAL OR ATTENDING PHYSICIAN.** The law requires that the death be executed within 24 hours after death. Page 4 may be

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**IMPORTANT:** If Item 31 is checked or Item 18 shows an injury, or other symptoms, please remove carbon paper and attach a detailed description of the injury or symptom to this card.

**IMPORTANT:** If item 21 is marked or item B shows any injury, or other traumatic event, the medical examiner must be notified.

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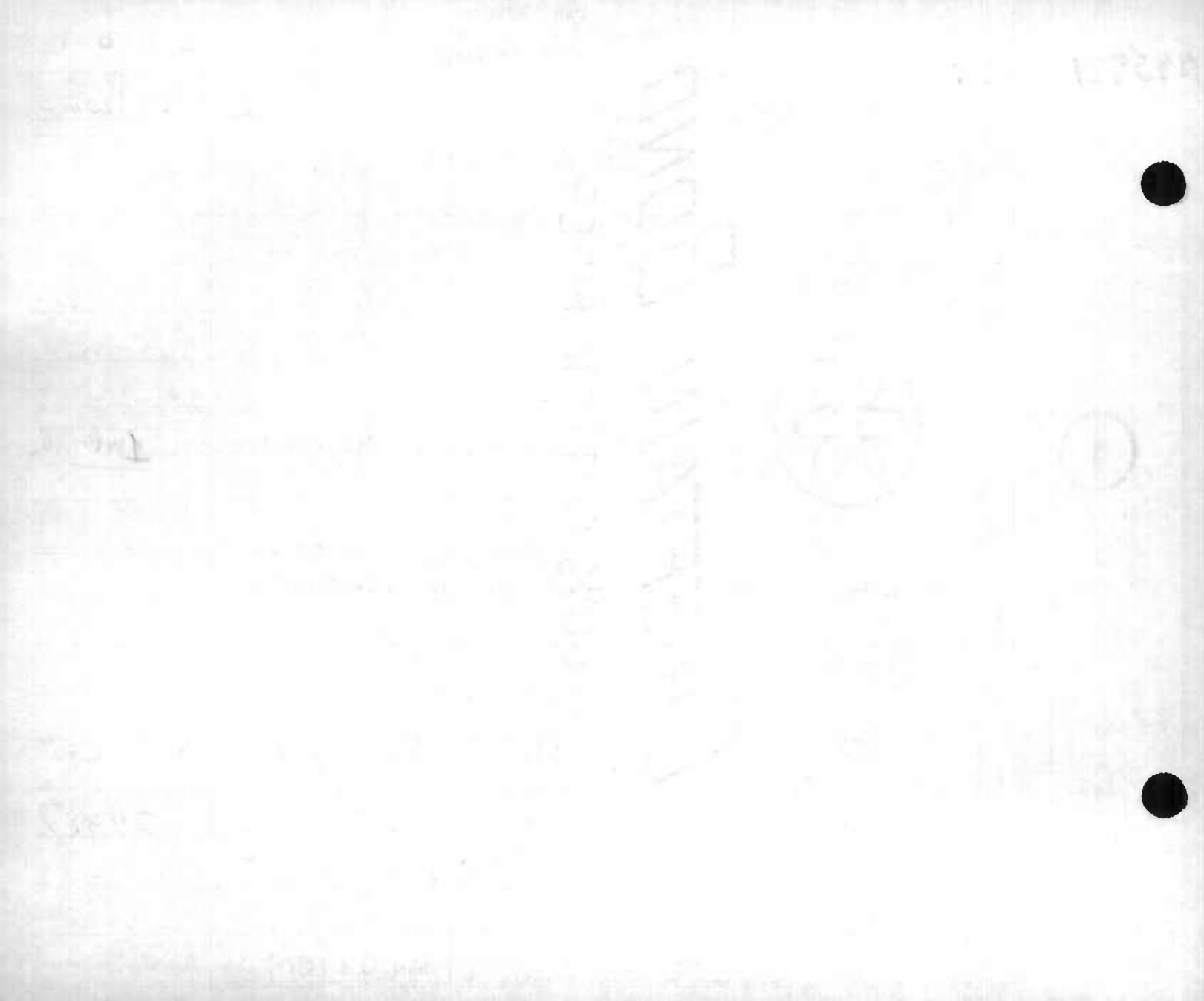
MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRATION

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

3 7 0 8 2 6  
REG. NO. 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
VERNON					PINDER			21287				1245PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
Male		Black		6 22 12			74							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Md.		U.S.						Dorchester			Cambridge			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Dorchester Gen Hospital						Laborer								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.		13b. COUNTY		13c. CITY OR TOWN					Box 450 Camb, Md. 21613					
Dorchester		Cambridge												
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Clarence						Bertha			Malock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS					
(If Yes, Give War or Dates)						244-30-7723			Janice Pinder / Camb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:						IMMEDIATE CAUSE (a) <u>Bilious rem physiol, Exacerbation</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) _____								
						DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						Diabetes mellitus, Salmonella UTI, noncompliance								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (the) hospital attended the deceased from <u>212</u> 11:2 19 87 to <u>212</u> 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>212</u> 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did <input checked="" type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <u>HUBERT L. FINGER</u>						DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/14/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. FINGER</u>						22e. ADDRESS <u>503 Brypn St</u>								
23a. BURIAL, CREMATION, REMOVAL HOSPITAL		23b. DATE <u>2/18/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Fork Neck Cem., Fork Neck</u>			23d. LOCATION CITY OR TOWN <u>Dorchester</u>			COUNTY <u>De</u>		STATE <u>chester</u>		
24. FUNERAL DIRECTOR NAME <u>Stewart Funeral Home Cambridge MD</u>		ADDRESS <u>Cambridge Rd.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 02 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			3/13/87			3:55 P.M.		
Charles WM. Rieck														
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 04 DAY 02 YEAR 1889			6. AGE (IN YEARS LAST BIRTHDAY) 97			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House NSC			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanical engineer			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Woolford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Laurie Lane 21677		
14. FATHER'S NAME Carl Wilhelm Rieck									15. MOTHER'S MAIDEN NAME Louise			16. LAST NAME Kingsley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 146-10-6558			17. INFORMANT Louise Willey Rt 1 Box 75 Woolford Md			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HT. DISEASE														
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS UNDET Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c) .														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSION														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from MAR 6, 1987, to MAR 13, 1987, that (I) (we) last saw the deceased alive on MAR 12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Alfred R. Maryanov, MD			22c. DEGREE						22d. DATE SIGNED 3/13/87					
22e. ADDRESS 610 Race St, Cambridge, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 3/14/87			23c. NAME OF CEMETERY OR CREMATORIAL SALISBURY CREMATORY			23d. LOCATION CITY OR TOWN SALISBURY COUNTY WIC. STATE MD.					
24. FUNERAL DIRECTOR NAME Ronald Funeral Home			25a. DATE REC'D. BY REGISTRAR MAR 16 1987						25b. REGISTRAR'S SIGNATURE Julia Dawson-Reader					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified. If item 21 is marked, the medical examiner should be notified of death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8108205
1 - STATE REGISTRAR			2a DECEASED NAME (TYPE OR PRINT)			2b DATE OF DEATH MONTH DAY YEAR			2b HOUR			
			MYRON W ROBINSON			3 20 87			2:15 PM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			
MALE			WHITE			2 2 08			79 YRS			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			
Md.			U.S.A.			NEVER MARRIED DIVORCED			MD.			
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DORCHESTER GENERAL			12a. USUAL OCCUPATION Retired			12b. KIND OF BUSINESS OR INDUSTRY Unknown			
13a. STATE Md.			13c. CITY OR TOWN Dorchester Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 800 Travers St. Apt. 6			
14. FATHER'S NAME Otto Robinson			15. MOTHER'S MAIDEN NAME MATILDA Woodburn			16. ADDRESS 800 Traver St. Louise-Robinson Cambridge Md.			17. INFORMANT WINGATE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO UNKNOWN			16b. SOCIAL SECURITY NO. 214-07-7398			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardioembolic shock DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cocaine Smoker												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/20 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									COUNTY			
22b. SIGNATURE Hubert L. Fiery			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			STATE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Fiery			22e. ADDRESS 503 BYRN ST.						22f. DATE SIGNED 3/20/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 3/22/87			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk.			23d. LOCATION CITY OR TOWN Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR MAR 24 1987			25b. REGISTRAR'S SIGNATURE Julia Johnson Reddick			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that  
rejoined by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by  
you, it should be detached for use as the burial/transit permit. Then please affix your stamp or signature  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.IMPORTANT: If item 21 is marked "D", show any injury, or other traumatic event, that  
occurred in connection with the death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 08204		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 3-29-87									2b. HOUR 8:15 PM		
1. DECEASED NAME FIRST Ava MIDDLE Delahay LAST ROE AVA			5. DATE OF BIRTH MONTH DAY YEAR 04-03-91			6. AGE (IN YEARS LAST BIRTHDAY) 95 yrs			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 14 HRS. HOURS MIN.		
7. SEX Female			8. RACE White			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NSY Cambridge House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY QueenAnne's			13c. CITY OR TOWN Centreville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Tilghman Ave., 21617		
14. FATHER'S NAME FIRST William MIDDLE Spedden LAST Delahay						15. MOTHER'S MAIDEN NAME FIRST Roberta MIDDLE Carville LAST Lowe								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-80-0588			17. INFORMANT Daughter			ADDRESS P.O. Box 320					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Mrs. Sara Catherine Valliant, Centreville, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)			ASCVD & A. Fibrillation		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Organic B. Syndrome														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.														
22b. SIGNATURE E. Tanman			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3-29-87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman			22f. ADDRESS 17 Franklin St. Cambridge, MD 21613											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 1, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery			23d. LOCATION CITY OR TOWN Centreville, Q.A.Co., Md.			STATE		
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617			25a. DATE REC'D. BY REGISTRAR APR 06 1987			25b. REGISTRAR'S SIGNATURE Julia Dandrea								
ADDRESS														

This certificate must be executed within 24 hours after death. Page 4 may be attached to this page and completed later.

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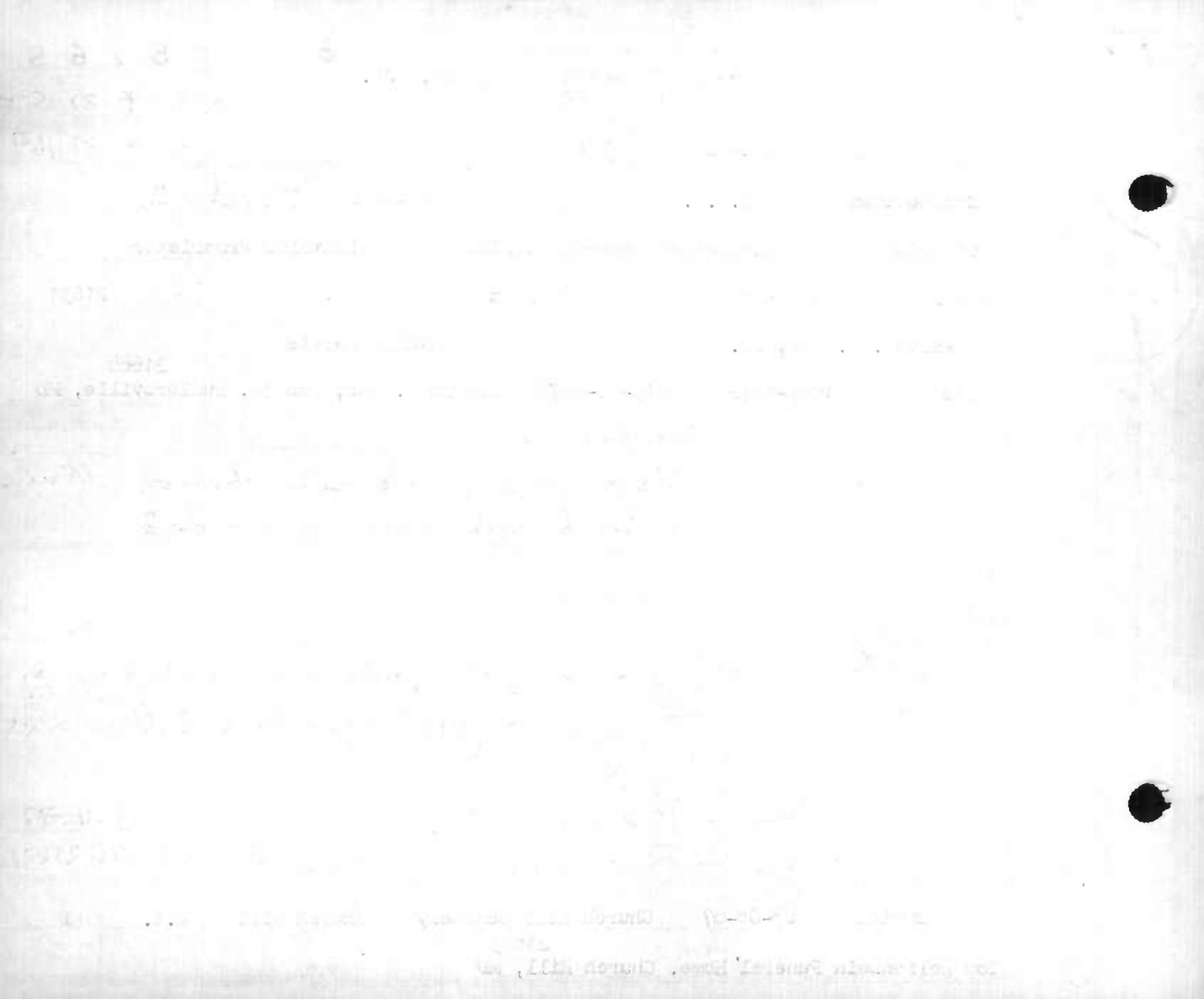
1988 80 99A

4/14

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

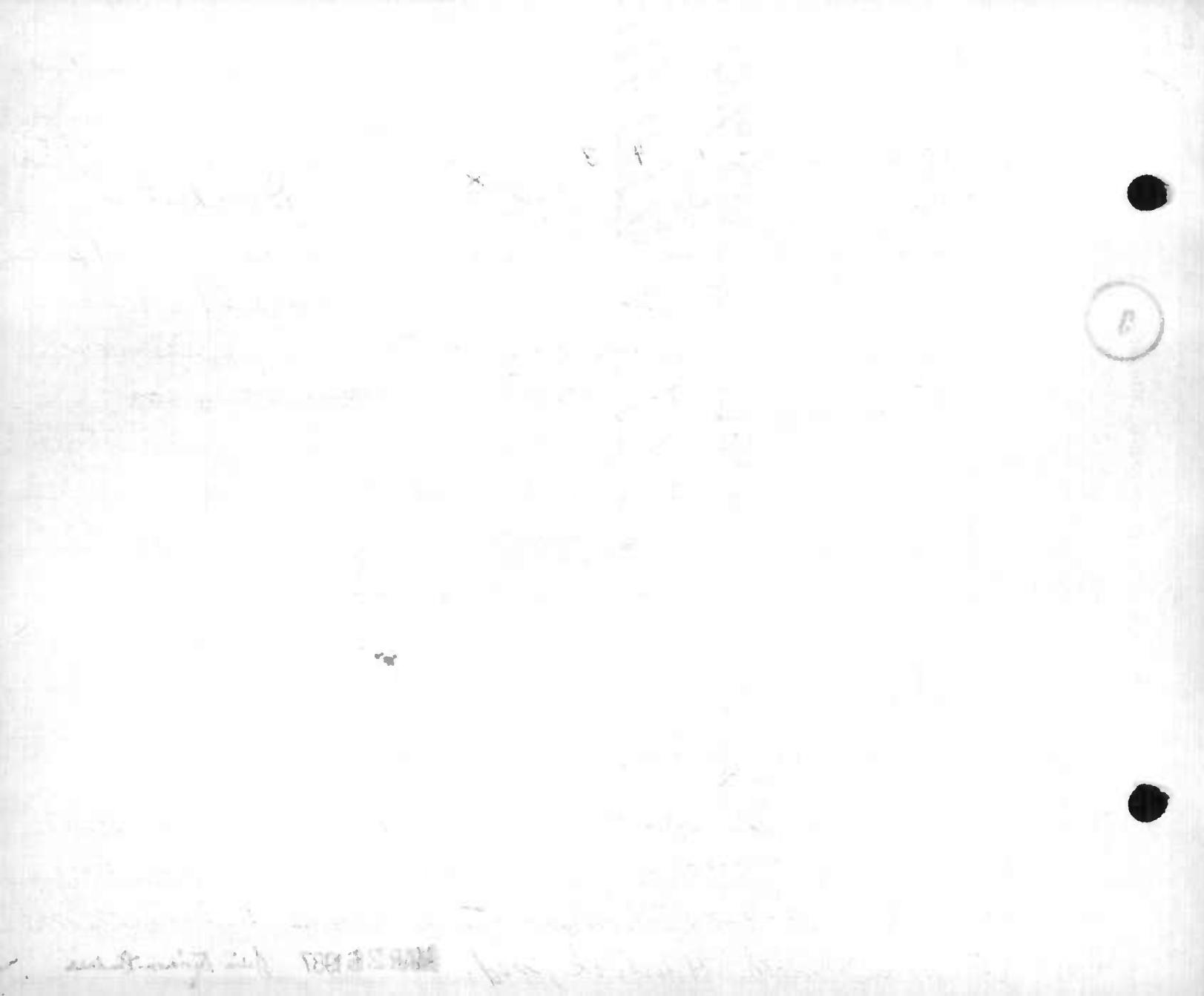
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08265		
1. DECEASED NAME (TYPE OR PRINT)				FIRST Walter	MIDDLE Emmett	LAST Roe, Jr.	Roe Jr.	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH X 3	DAY 4	YEAR 1987	2b. HOUR 1502 M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 3	DAY 4	YEAR 1987	2d. HOUR 1627 M
Male		White		09-14-47	39 yrs							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester
Chestertown				U.S.A.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge		Dorchester General Hospital				Nightclub Proprietor						
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN East New Market		14. FATHER'S NAME FIRST Walter. E. Roe, Sr.		15. MOTHER'S MAIDEN NAME FIRST Evelyn Morris		13e. STREET ADDRESS Rt. Box 152 21631		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 1967-1972		16c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. INFORMANT Evelyn M. Roe, Box 38, Sudlersville, MD		ADDRESS 21668			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
Yes		219-46-2675										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Massive aspiration of stomach content and compression of chest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>content and compression of chest</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 20. DATE OF OPERATION 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 15 P.M. 3-4 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Jack collapsed - crushed by car		21d. LOCATION STREET Golden Nugget R+16-E-NewMarket CITY OR TOWN COUNTY STATE						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter W. Rieckert</u> TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert ADDRESS E-New Market Ed. 21631 DATE SIGNED 3-4-87												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 03-08-87		23c. NAME OF CEMETERY OR CREMATORIAL Church Hill Cemetery		23d. LOCATION CITY OR TOWN Church Hill		23e. COUNTY Q.A.		23f. STATE MD		
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Church Hill, MD		ADDRESS 21623		25a. DATE REC'D. BY REGISTRAR MAR 12 1987		25b. REGISTRAR'S SIGNATURE J. M. Helfenbein						
BP _____												
DHMH-17 (VR A15 ME (5)) 15M 2/80												



048257 MAR 5

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08206					
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- MATED									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH DAY YEAR		19			
THOMAS			L.			L.			SAMPSON			MAY 27 1987		5 PM			
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE   IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male Black				2 - 21 - 1914			73 yrs.			MONTHS		DAYS		HOURS		MIN.	
7e. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?		8.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester							
Md.		U.S.															
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS Dorchester General		12a. USUAL OCCUPATION [FOR MOST OF WORKING LIFE] Laborer		12b. KIND OF BUSINESS OR INDUSTRY Food processing											
Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Hunlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9TH & BOSTON 61		21643							
14. FATHER'S NAME First Eugene		MIDDLE Sampson		LAST		15. MOTHER'S MAIDEN NAME First Martine		Middle		Last Casper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN]		16b. SOCIAL SECURITY NO. No		16c. INFORMANT 220-10-6638		17. ADDRESS Mrs. Daisy Sampson											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED					
(b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF												YEARS					
(c) <u>DIABETES MELLITUS</u>												YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2]											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER					
ACTUAL SIGNATURE James F. McCarter		DATE SIGNED 3-2-87															
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 400 AURORA ST., CAMBRIDGE, MD. 21613														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 400 AURORA ST., CAMBRIDGE, MD. 21613														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3-4-87			23c. NAME OF CEMETERY OR CREMATORIAL Thompson's			23d. LOCATION CITY OR TOWN Thompson's		COUNTY	STATE					
Burial			3-4-87			Thompson's			Thompson's		Dorchester	Md.					
24. FUNERAL DIRECTOR NAME Bennie Smith			ADDRESS Hunlock, Md.			25a. DATE REC'D. BY REGISTRAR MAR 26 1987			25b. REGISTRAR'S SIGNATURE Julia Division-Andrea								
BP _____																	
DHMH-17 (VR A15 ME (5))																	
15M 2/20																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, the medical examiner must be notified.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08267							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
LOUISE C. SANDERS						March 20 87						112 P M							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
FEMALE		CAU.		Aug. 30, 1893			93			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		U.S.A.						DORCHESTER			MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
CAMBRIDGE		DORCHESTER GENERAL HOSP.			homemaker			---											
13a. STATE MARYLAND												13b. CITY OR TOWN DORCHESTER		13c. CITY OR TOWN MADISON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE rural Zip: 21648	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST										
LEVIN			EDWARD	BROMWELL	SUSAN					CLARK									
16a. WAS EVER DRAFTED IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT daughter			ADDRESS										
NO			218-16-6727D			Mrs. Martha Evans, Stoneboundary Rd.			Rt 4 Box 26 21613										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac standstill</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minute							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rapid atrial fibrillation</u> (c) <u>dehydration</u>												DUE TO, OR AS A CONSEQUENCE OF 1 day							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Acute Gastroenteritis</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 87</u> to <u>March 20 87</u> , that (I) (we) last saw the deceased alive on <u>March 20 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <u>Edmund J. MacLaughlin</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/20/87										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edmund J. MacLaughlin</u>			22e. ADDRESS 10 Aurora St. Cambridge Md 21613																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 3/23/87			23c. NAME OF CEMETERY OR CREMATORIUM Joppa Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Madison, Dorchester, Md.										
24. FUNERAL DIRECTOR NAME			CURRAN FUNERAL HOME 308 High St., Cambridge, Md. 21613			25a. DATE REC'D. BY REGISTRAR MAR 24 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Rudace</u>										

be executed within 24 hours after death. Page 4 may be



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other humerical grant, the medical certificate must be filled in by the funeral director. page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please return carbon copies, Pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8708208	
										REG. NO.	
1. DECEASED NAME * FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR	
Clinton R. Simmons										3-11-87	11:15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR			
MALE		WHITE		2 24 99		88		11:15 AM			
7d. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Dorchester County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>									
Cambridge		Dorchester General Hosp.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.				Dorchester Fishing Creek		NO		Rt #1 Box 62 21634			
14. FATHER'S NAME *		MIDDLE		LAST		15. MOTHER'S MARRIED NAME					
Major Thomas Simmons						Rebecca William					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Unknown		No 244-10-9773		Clinton M. Simmons		Rt 1 Box 62 Trappe, Md. 21673					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRAM - NEGATIVE SEPSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 D 94	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>URINARY TRACT INFECTION</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>87</u> , to <u>3/11</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				<u>3/11/87</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY STATE			
Burial		3/13/87		Hesier Churchyard		Fishing Creek		Dor Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS				25. DATE REC'D. BY REGISTRAR'S OFFICE REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME CAMBRIDGE. MD.						MAR 13 1987 Julie Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that if a death certificate be executed by a physician,

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then page 3 should be filed with the state Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

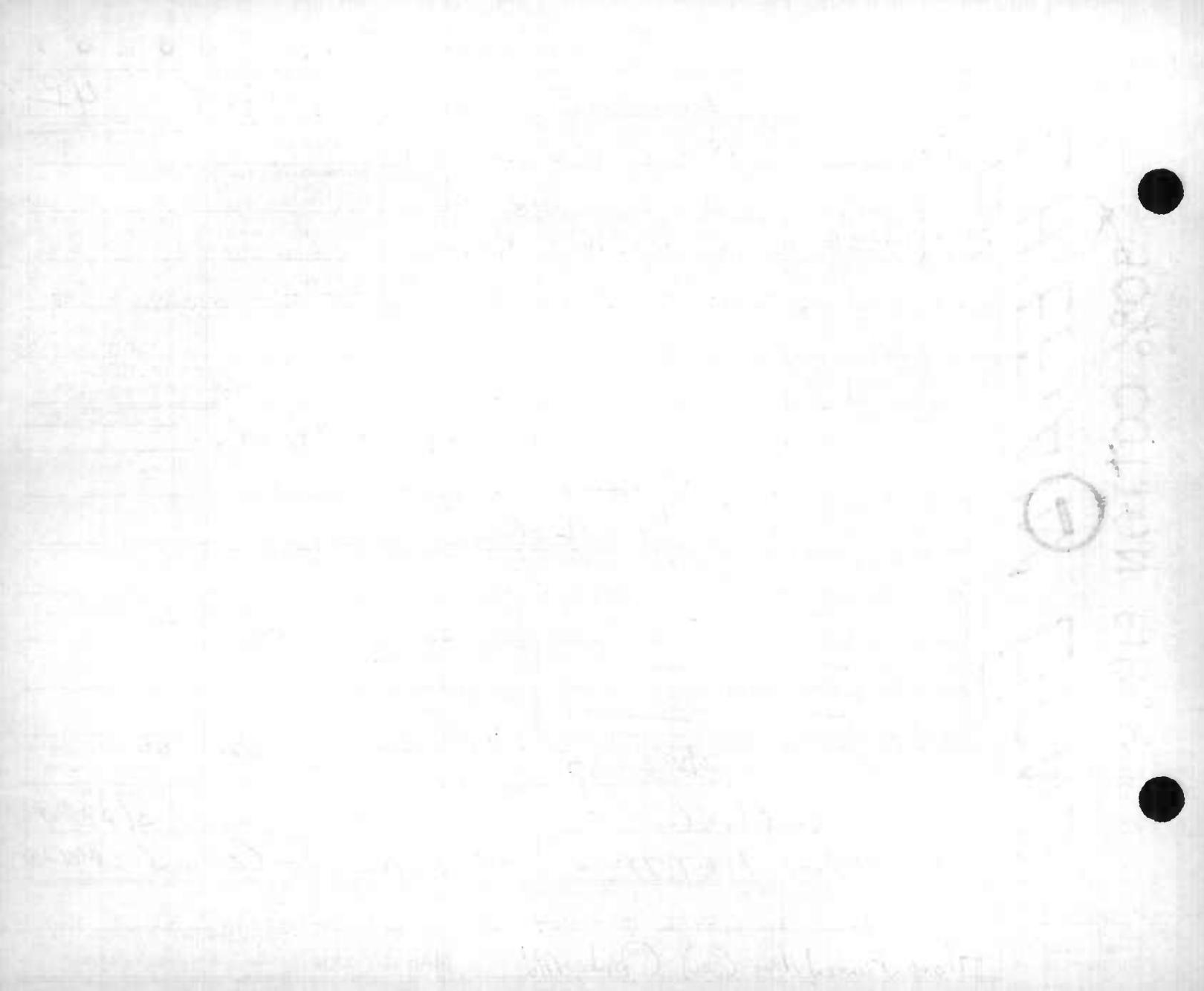
REG. NO.

8 / 08269

3. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Evelyn			L.	Leonard	Slacum	3/21/87			77	41 <sup>m</sup>		
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White	06	25	09	77		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			US					Dorchester Co. MD.				
10. CITY OR TOWN OF DEATH <i>Dorchester Cambridge</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House Hosp</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 520 Glenburn Ave 21613			
14. FATHER'S NAME FIRST Charles			MIDDLE C.	LAST Leonard	15. MOTHER'S MAIDEN NAME FIRST Rose			MIDDLE Cannon	LAST Preston, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 214-07-8308			17. INFORMANT Lillian Butler Rt 1 Box 151 T21655			ADDRESS			
PART 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mesasma. Dors</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Typhoid</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/20</i> 19 <i>87</i> , to <i>3/1</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>2/20</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Dr. Marshall</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 3/28/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Vinod K. Mehta</i>		22e. ADDRESS <i>410 Forum &amp; Cambridge Rd 21613</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/29/87		23c. NAME OF CEMETERY OR CREMATORIUM Dor Mem Park		23d. LOCATION CITY OR TOWN Cambridge		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>Thomas Funeral Home (Gen)</i>		ADDRESS <i>Camb. Md.</i>		25a. DATE REC'D. BY REGISTRAR MAR 27 1987		25b. REGISTRAR'S SIGNATURE <i>John D. Danner, Registrar</i>						

Page 4 may be  
reached for death. Page 3

should be filed with the state Dept. of Health and Mental Hygiene prior to burial or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use in the burial-trunk permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 / 08 27 0	
												REG. NO.	
1 - STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			LEON H. STANLEY						3 26 87			6:00 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
M			NEGRO			6 23 09			77			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Md			U.S.						Dorchester			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			Dorchester Gen Hospital			Retired							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md.			Dorchester-Cambridge						RT 3 Cambridge 21613				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Cornelius			Elvira S Camper										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
(If yes, give war or dates)			220-09-1794 Louise Stanley RT 3 Cambridge, MD										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure 24 hours													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c) Severe end Stage pulmonary hypertension ≈ 1 mo													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
CHD													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/26/87 to 3/27/87, that (I) (we) lost saw the deceased alive on 3/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death													
22b. SIGNATURE HUBERT L. GERRY			DEGREE			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/26/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. GERRY			22e. ADDRESS 503 BYRN ST										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/31/87			23c. NAME OF CEMETERY OR CREMATORIAL Bucktown Cone.			23d. LOCATION CITY OR TOWN Bucktown Dor. Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
Stewart Fare-a-Home Cambridge, Md.						APR - 1 1987			Julia Gordon-Lindell				

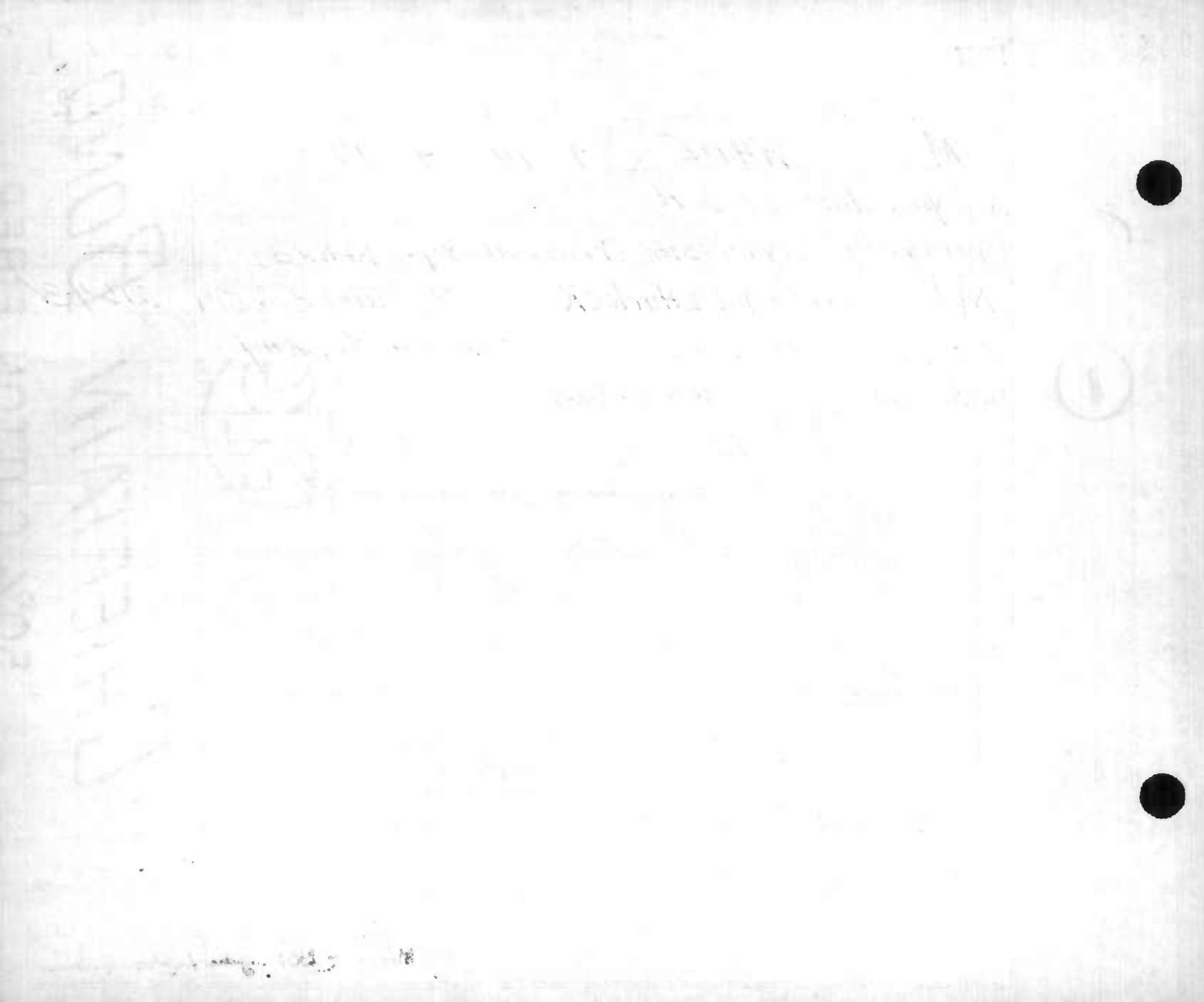
(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked as "No," show one injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 08271				
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR 3 <sup>50</sup> A.M.	
Victor L. Thomas									3 6 87							
3. SEX <b>M</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH 7 DAY 14 YEAR 07			6. AGE (IN YEARS LAST BIRTHDAY) 77 79 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>New York State</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>			MD.				
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET & ADDRESS) <b>Dorchester General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired auditor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>STATE</b>							
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dorchester &amp; Hurlock</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Rt#1 Box 519 21643</b>							
14. FATHER'S NAME <b>Stephen Thomas</b>						15. MOTHER'S MIDDEN NAME <b>Cecelia RepKAY</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? LIFE, DEATH UNKNOWN <b>WW II</b>			16b. SOCIAL SECURITY NO. <b>069-05-8421</b>			17. INFORMANT <b>Mrs. Thomas</b>			ADDRESS <b>Hurlock Md. 21643</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))      PART I. DEATH WAS CAUSED BY:      IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>      DUE TO, OR AS A CONSEQUENCE OF      Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).      (b) <u>Congestive cardiomyopathy</u>      DUE TO, OR AS A CONSEQUENCE OF      (c) <u>ASCVD</u></p>																
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
<p>22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 3-6 19 87, that (I) (we) last saw the deceased alive on 3-5 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</p>																
22b. SIGNATURE <u>Michael J. Fadden</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael J. Fadden</b>			22f. ADDRESS <b>302 Collier St., Hurlock Md. 21643</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>3/9/87</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Our Lady Good Counsel Churchyard, Secretary Md.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>			ADDRESS <b>CAMBRIDGE MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 09 1987</b>			25b. REGISTRAR'S SIGNATURE <b>John Deacon Kindred</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please return the completed part. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 08272						
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Walter A. Thompson									2	22	87	90	90 P.M.			
3. SEX male			4 RACE Black			5. DATE OF BIRTH MONTH 04 DAY 06 YEAR 09			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester							
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Genesis (Cambridge House)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landscaping			12b. KIND OF BUSINESS OR INDUSTRY Landscaping							
13a. STATE Maryland			13b. COUNTY Dorchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 411 Cedar Street 21613							
14. FATHER'S NAME FIRST Fred MIDDLE Thompson LAST			15. MOTHER'S MAIDEN NAME Henrietta			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-10-6952			17. INFORMANT ADDRESS Cecelia Stanley, Rt. 2, Box 108, Md.			Ross Hurlock,	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>87</u> , to <u>2/22</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>Chas. Newell</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/22/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINTON KIRKETT			22e. ADDRESS 400 Aurora St Cambridge MD 21613													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 27, 1987			23c. NAME OF CEMETERY OR CREMATORIAL E. New Market Cem.			23d. LOCATION CITY OR TOWN E. New Market, Maryland							
24. FUNERAL DIRECTOR NAME <u>F. H. Hawkins</u> ADDRESS <u>FEDERAL 133</u>			25a. DATE REC'D. BY REGISTRAR MAR 09 1987			25b. REGISTRAR'S SIGNATURE Julia Darden-Readess										

Documenter

U.S.A.

East Asia

possible. Perhaps

III cedar forest

goldenseal, ginseng

sage, licorice, rhubarb

lemon

fern

550-11-0225 Cossatot River, DE, Box 118

to

①

possibly, just west of the bridge over the river.

about 1000 ft. above sea level

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

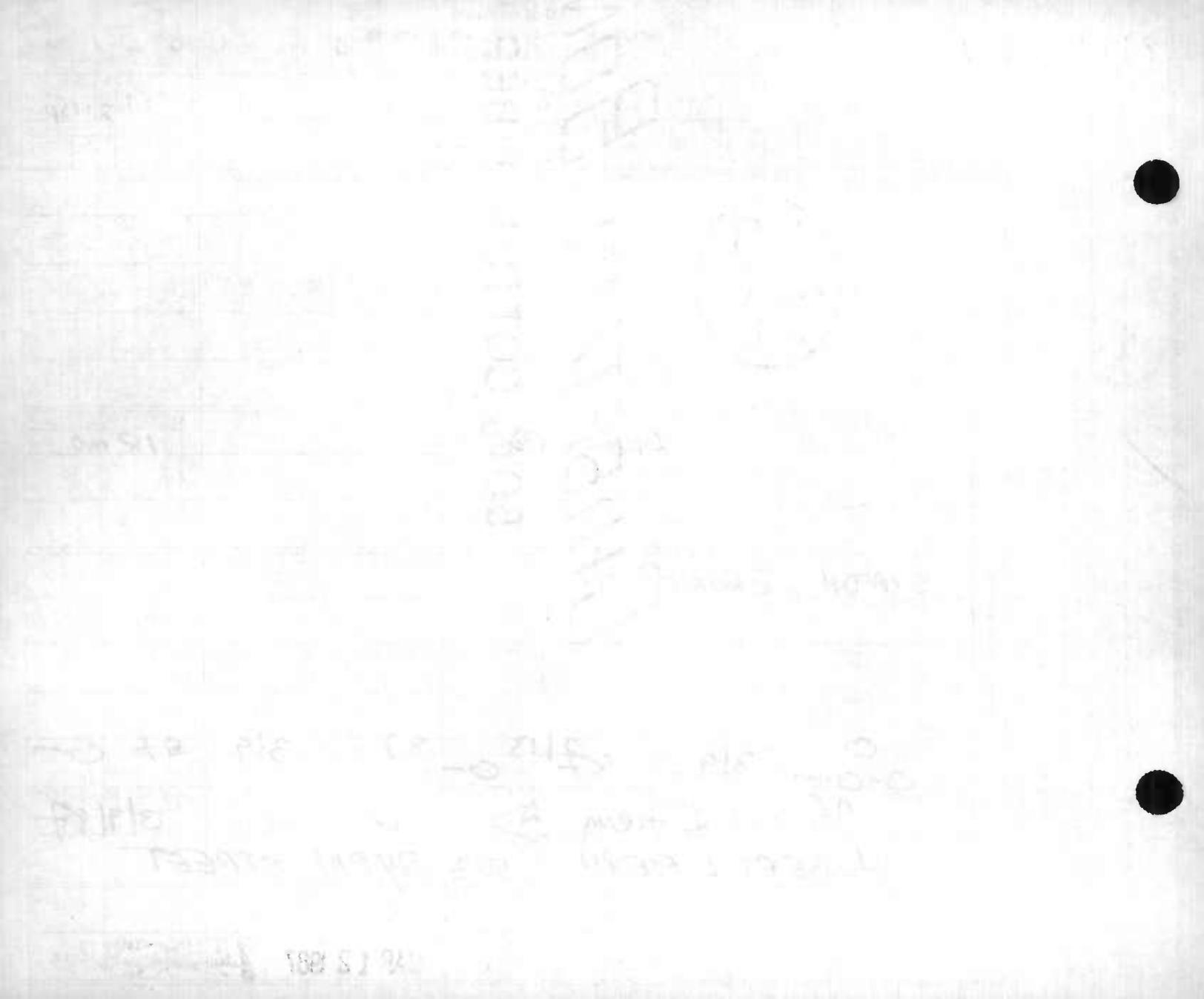
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 7 (and 2) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "No" Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

1. DECEASED NAME FIRST JAMES MIDDLE PAUL LAST TWIGG					2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
1. SEX MALE		4 RACE CAU.	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 59		IE UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGERIAL		12b. KIND OF BUSINESS OR INDUSTRY RETAIL
13a. STATE MARYLAND		13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 25 Algonquin Rd. 21613		
14. FATHER'S NAME FIRST ARLEY MIDDLE LESTER LAST TWIGG		15. MOTHER'S MAIDEN NAME FIRST DOROTHY MIDDLE EVELYN LAST RITTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII 213-22-2697		17. INFORMANT wife ADDRESS Mrs. Carola Allen Twigg, same as 13e		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Ca DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SIADH, Bronchitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21/13 19 87				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 319	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	319 87			
22a. I certify that (if this hospital) attended the deceased from 21/13 19 87 to 319 87, that (if two less than 24 hours) saw the deceased alive on 319 19 87, and that in my opinion death occurred on the date and hour and from the causes stated above. (If two days did not view the body after death.)							
22b. SIGNATURE HUBERT L. FERRY		22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/9/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. FERRY		22e. ADDRESS 503 BYRN STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/14/87	23c. NAME OF CEMETERY OR CREMATORIUM Rocky Gap Vet. Cem.		23d. LOCATION TOWNSHIP CUMBERLAND COUNTY Md. STATE		
24. FUNERAL DIRECTOR NAME 1111 308 High St., Cambridge, Md.		24a. DATE REC'D. BY REGISTRAR MAR 12 1987		24b. TELEGRAMS TO 1111 308 High St., Cambridge, Md.			

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by you, it should be detached for use as the burial transit permit. Then please send the original to the State Dept. of Health and Mental Hygiene prior to burial, or to the hospital or attending physician if he is deceased.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other condition contributing to death, attach a separate sheet.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3 / 08214
1 - STATE REGISTRAR		2a DATE OF DEATH MONTH DAY HOUR										
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		MONTH		DAY		2b HOUR		
<i>Blanche L. Vincent</i>						APRIL		23		7 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
Female		White		April 23, 1890		96 YRS						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		US				Dorchester Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
<i>Cambridge</i>		<i>Cambridge House</i>										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		606 William St. 21613		Teacher		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
Francis H. Vincent				Mary Vane								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		220-44-2517		Jean Vincent Item # 13				UNDET				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HT. DISEASE</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> UNDET												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> , 19 <u>87</u> , to <u>3/7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Alfred R. Maryanov</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/7/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfred R. Maryanov</i>		22e. ADDRESS 610 Race St, Cambridge MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/10/87		23c. NAME OF CEMETERY OR CREMATORIAL E. New Mkt Cem		23d. LOCATION CITY OR TOWN E. New Mkt Dor Md.		23e. COUNTY 21613				
24. FUNERAL DIRECTOR NAME <i>Thomas Funeral Home Camb.</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 11 1987		25b. REGISTRAR'S SIGNATURE <i>J. J. Schaefer</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)												

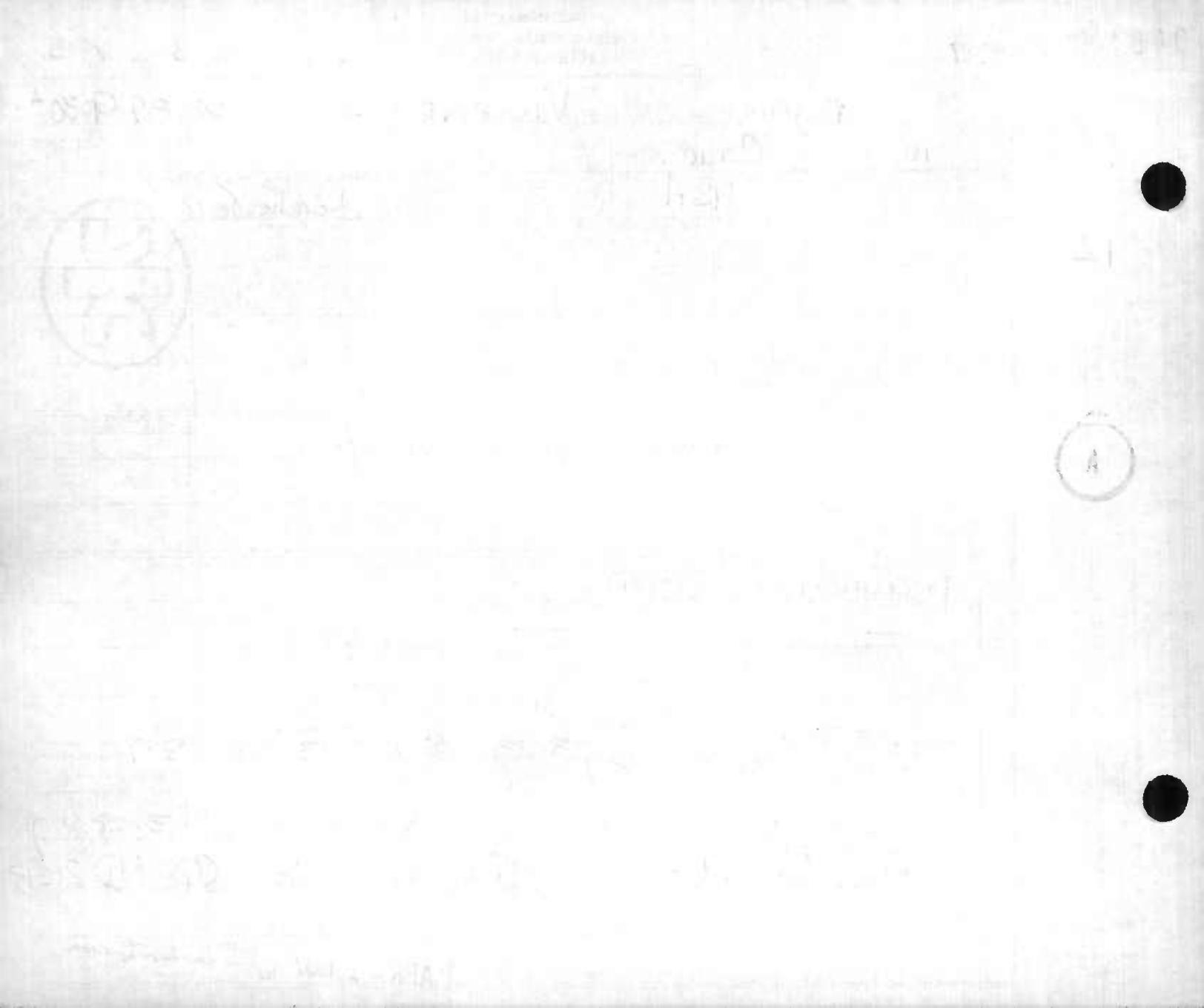
B.G.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remain in contact with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. Item 21 is marked or item 18 shows any injury, or other findings present, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 08275	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
JULIAN Anstine			VINCENT			3 28 87			9:30 A.M.		
3. SEX M. Male			4 RACE Cauc White			5. DATE OF BIRTH MONTH DAY YEAR Sept 30, 1892			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 94 YRS.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Worker			12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Francis Hayward			LAST Vincent			15. MOTHER'S MAIDEN NAME Mary			16. ADDRESS Vane		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 717-12-3143			17. INFORMANT Elva W. Vincent			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable ruptured Viscus</u>											
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia, COPD</u> .											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (We) attended the deceased from <u>3.28.87</u> , 19 <u>87</u> , to <u>3.28.87</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>3.28.87</u> , 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.											
22b. SIGNATURE <u>Debbie</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>3.28.87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. J. Wilce</u>			22e. ADDRESS <u>4cc md Ave</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/31/87			23c. NAME OF CEMETERY OR CREMATORIAL Dor Memorial Park			23d. LOCATION CITY OR TOWN Cambridge Dor COUNTY Md.		
24. FUNERAL DIRECTOR NAME Thomas FUNERAL HOME CAMBRIDGE, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR - 1 1987			25b. REGISTRAR'S SIGNATURE <u>John Gardner</u>		
DHMH - 16 60M 7/84 (VRA 15, 4)											



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECREMATION.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 8 2 1 6	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR	
William Leonard Wheatley						<input checked="" type="checkbox"/>			3	4	19 87	A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Male	White	9/11/1911	75	MONTHS	DAYS	HOURS	MIN.		3	4	19 87	4 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		US						Dorchester Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Rt 3 Box 69			Waterman			21613					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Dorchester		Cambridge				411 High Street					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
William		Steele	Wheatley	Eva		May	Seward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		220-01-8155		Arthur Wheatley		Rt 3 Box 69		Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia due to squamous cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>left upper lobe</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
										<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		<u>Peter W. Rieckert</u>		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		Peter W. Rieckert, M. D.								DATE SIGNED 3-5-87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/6/87		23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cemetery		23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor		STATE Md.			
24. FUNERAL DIRECTOR THOMAS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR 21613 25b. REGISTRAR'S SIGNATURE <u>Marky 881</u>											
BP													
DHMH-17 (VR A15 ME (5)) 15M 2/80													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper(s) page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician should be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 / 0 8 2 1 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Russell Lee</i>					<i>Wheedleton</i>	<i>3 26 87</i>				<i>5:30 p.m.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Male</i>		<i>White</i>		<i>Dec. 14, 1929</i>		<i>57</i>		<i>MONTHS DAYS</i>		<i>HOURS MIN.</i>	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>Federalsburg, Md.</i>		<i>U.S.A.</i>				<i>Dorchester</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Cambridge, Md.</i>		<i>Dorchester General Hospital</i>		<i>Electrician</i>							
13. STATE <i>Maryland</i>											
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		MD. <i>Rt. 1, Box 170C 21631</i>			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
<i>Ollie Lee</i>		<i>Wheedleton</i>				<i>Velma Herceilia</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
<i>Yes</i>		<i>Korean</i>		<i>214-28-1643</i>		<i>Glen A. Payne, Rt. 1, Box 170C, Md. 21631</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Brain Tumors</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Schizophrenia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. Tannan</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/26/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tannan</i>		22e. ADDRESS <i>17 Franklin St. Cambridge MD 21613</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial Mar. 29, 1987</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Zion Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Nr. Federalsburg, Maryland</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Frampton-Hawkins Funeral Home, 216 N. Market</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>APR 02 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Scidmore Leader</i>					

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negative image of the original  
negative. The original negative was  
positioned over the surface of the  
film frame and the negative was  
exposed. The negative was then  
reversed and the original  
negative was placed over the  
original negative. The original  
negative was then exposed again.  
This process was repeated until  
the original negative was  
reversed.

negative was then placed over the original negative.  
The original negative was then exposed again.  
This process was repeated until  
the original negative was  
reversed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the hospital or attending physician, it should be deposited for safe-keeping in the burial transit permit. Then please remove carbon paper. Item 21 should be filed within 72 hours of death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 / 08218

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 125 AM	
Pauline Mabel Whitten						3	17	87		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS			IF UNDER 1 YEAR MONTHS DAYS	
<input checked="" type="checkbox"/> Female		<input checked="" type="checkbox"/> White		8 9 11		75			IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		US				Dorchester Co. MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital		Homemaker						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		
Maryland		Dorchester		Cambridge				515 Academy St. 21613		
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST		LAST		
Howard				Henry		Eva		Elizabeth Marine		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
No		213-42-2375		Oliver H. Whitten Item # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months										
DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Years										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes mellitus										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/16 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				19 87		to 3/17		19 87		
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS								3/17/87
H. E. Acliffe		408 Brynn St. Cambridge, Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial		3/19/87		E. New Mkt Cemetery		E. New Mkt. Bur. Md.				
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
THOMAS FUNERAL HOME CAMBRIDGE, MD.				MAR 20 1987		Julia Feil				

Book collection

